Health Insurance Coverage for Mental Illness

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TODAY in the United States approximately 116 million people have some health insurance coverage for hospital care: 101 million, for surgical service; 65 million, for medical service in the hospital; and 9 million, for physician service in the office, clinic, and home. Major health insurance carriers are the Blue Cross and Blue Shield plans, insurance companies through group and individual policies, and independent plans. The last type includes company and union self-insured plans, community-sponsored plans, and prepayment programs offered by private medical groups. Table 1 shows the number of persons covered for the various services by each type of plan.

Prepayment plans generally provide less extensive coverage for mental illness than for other types of illness. In part at least, this is due to the long duration of mental illness, to the fact that mental illness has traditionally been considered as separate and apart from other illness, and to the fact that much of the hospitalization for mental illness is provided in government hospitals at little or no cost to the patient or his family.

The lesser coverage for mental illness creates problems for the subscribing public, for hospitals, and for the medical profession in general and psychiatrists in particular. To elucidate the present situation as regards coverage, I shall describe in turn the practices of each type of plan.

Blue Cross Plans

Most of the 80 Blue Cross plans in the United States offer two or more, and some a whole host of, subscriber contracts with varying provisions regarding duration of benefits, type of room or amount of room allowances, and the like. Some provide better coverage of mental and nervous cases (the terminology generally used by the plans) under one contract than under another. I shall deal only with the most extensive contracts of each plan.

The plans provide far less extensive coverage of mental illness than of other types of illness in general hospitals, and they provide far less extensive coverage of mental illness in mental than in general hospitals (table 2). The majority of the plans provide a maximum of between 60 and 120 days of care, generally per admission, for general illness. By contrast, 18 of the 80 plans provide no coverage whatever of mental and nervous cases in general hospitals, 3 provide coverage only until diagnosis as a mental case, and 1 covers for shock therapy or surgery only. Of the remaining plans, 8 provide 7 to 20 days of coverage, and 27, or about a third, between 21 and 30 days. Only 16

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Table 1. Health insurance coverage in the United States, by type of coverage, according to type of carrier, Dec. 31, 1956

[Thousands of persons covered]

Type of carrier	Type of coverage					
	Hospital care	Surgical service	Medical service in—		Supplementary major medical policies	Comprehensive medical expense policies
			Hospital	Office and home		
Blue Cross-Blue Shield and other plans sponsored by medical societies	53, 162	42, 570	33, 907	3, 000	(1)	0
Insurance companies:						
Group policies	45, 211	45, 906	25, 177	2, 000	6, 872	1, 413
Individual policies	27, 629	23, 074	6, 789	500	587	0
Independent plans	4, 654	4, 909	5, 276	3, 500	0	0
Gross total	130, 656	116, 459	71, 149	9, 000	7, 459	1, 413
Deduction for duplicate coverage	14, 707	15, 134	6, 258	300	0	0
Net total	115, 949	101, 325	64, 891	8, 700	[1] 7, 459	1, 413

[1] A fair number of the Blue Cross-Blue Shield plans have "dread disease" or "prolonged illness" supplementary contracts or riders which offer a coverage somewhat analogous to the major medical expense policies of insurance companies. Also, a few plans have issued major medical contracts. The number of persons covered under these supplementary Blue Cross-Blue Shield contracts is not known; it is probably in excess of 4 million.

SOURCE: Data in all columns except "Medical service in office and home" are from the Health Insurance Council's The Extent of Voluntary Health Insurance Coverage in the United States as of December 31, 1956. Data in that column are my own rough estimates. The presentation of the data differs somewhat from that in the council's publication.

of the plans provide as many as 60 days of coverage in general hospitals. A few of the plans further limit coverage for mental illness by specifying that the prescribed number of days for mental care shall be the total provided during the lifetime of the member.

So far as I can calculate, approximately 30 percent of the plans provide the same coverage for mental cases in general hospitals as they provide for general illness; the remainder provide less or no coverage.

The coverage provided in mental hospitals is still less extensive. Almost half of the plans provide no coverage whatever; 3 cover only until diagnosis as a mental case; 1 covers for shock therapy or surgery only; 5 provide less than 21 days; 23, between 21 and 30 days; and only 10, more than 30 days. In a number of the plans these days are the maximum provided for life. Two plans exclude all care in government hospitals, and several exclude care available without charge in government hospitals. These provisions indicate that there is some question as to whether the State mental hospitals of the area charge for their services or not.

Several plans provide extensive coverage for mental cases. One provides up to 120 days per admission in either general or mental hospitals. Three of the plans offer special riders to their regular policies which provide an extra coverage of mental cases. Two of these, one at a cost of 12 cents and another at 15 cents a month for a family, provide up to 30 days for mental cases in either general or mental hospitals. The third, at a cost of 10 cents a month for a family, will extend the coverage for mental cases from the 30 days available under its ordinary certificate to 120 days in either general or mental hospitals.

The provisions of the plans regarding alcoholism, drug addiction, and self-inflicted injuries (attempts at suicide) are pertinent here. About two-thirds of the plans provide some coverage for alcoholism and for drug addiction, and almost all cover self-inflicted injuries (table 3).

Blue Cross coverage of mental illness has distinctly improved over the past decade. Ten years ago half of the plans excluded all coverage even in general hospitals, and only 5 out of

81 plans provided benefits in general hospitals for as long as 31 days.

Blue Shield Plans

Of the 64 Blue Shield plans, 4 provide only surgical service, 51 cover surgical and inhospital medical service, and 9, under at least one of their contracts, also cover physicians' services in the office and home.

Thirty-three, or a few more than half, of the plans cover mental and nervous conditions on the same basis as all other conditions; 21 totally exclude these conditions; and the remaining 10 provide limited coverage (table 4). Mostly these last limit care to less than 30 days or to that provided in general hospitals.

Special interest attaches to the nine plans which offer comprehensive coverage of physicians' services, that is, care in the office, home, and hospital. Of these, 4 provide the same coverage for mental and nervous conditions as for other conditions; 1 totally excludes these conditions; 1 covers only shock treatments or surgery; 1 covers only diagnosis in the office; 1 excepts psychiatric treatment; and 1 provides coverage for only 30 days.

About two-thirds of all Blue Shield plans provide some coverage of alcoholism and drug addiction, and the great majority cover self-inflicted injuries (table 4).

Table 2. Blue Cross coverage for general conditions and for mental conditions in general and mental hospitals, January 1957: number of plans providing specified days under most extensive contract

Days of full-benefit care per admission or per year	General conditions	Mental conditions	
		General hospitals [1]	Mental hospitals [2]
No coverage	0	18	38
Until diagnosed	0	3	3
For shock therapy and surgery only	0	1	1
1–10	0	4	3
11–20	0	4	2
21–30	8	27	[3] 23
31–60	7	[3] 7	4
61–90	22	3	3
91–120	31	[3] 9	[3] 3
121–180	3	2	0
181–365	4	0	0
366–730	4	1	0
731–850	1	[4] 1	0
Total	80	80	80

[1] 9 plans provide the specified days as a maximum during life of member.
[2] 8 plans provide the specified days as a maximum during life of member.
[3] 1 excludes care in all government hospitals.
[4] In acute general hospitals only.

SOURCE: Compiled from data in Blue Cross Guide, January 1957.

Table 3. Blue Cross coverage of alcoholism, drug addiction, and self-inflicted injuries, January 1957: number of plans with designated provision under most extensive contract

Provision	Alcoholism	Drug addiction	Self-inflicted injuries
Not covered	29	26	6
Covered until diagnosed	1	1	1
Covered on same terms as general conditions	17	23	63
Covered but in participating or general hospitals only	13	10	3
Covered in all types of hospitals but for fewer days than other cases:			
Less than 20 days	4	4	0
20–31 days	10	8	0
Covered but in participating or general hospitals only, and for fewer days than other cases:			
Less than 20 days	1	1	0
20–31 days	2	2	4
More than 32 days	0	1	0
Covered in participating or general hospitals and for limited periods in other hospitals	2	1	1
Other provisions [1]	1	3	2
Total	80	80	80

[1] Mainly covered in general hospitals but not in specified types of government hospitals.

SOURCE: Compiled from data in Blue Cross Guide, January 1957.

Insurance Companies

I shall deal first with group policies and then with individual policies.

Group insurance plans sold by insurance companies generally provide hospitalization coverage for 31 days or 70 days, occasionally for 120 days, and rarely for 180 days. With rare exceptions, these policies provide the same coverage for mental illness, alcoholism, drug addiction, and self-inflicted injuries as for all other

types of cases, and without distinction as to type of hospital.

Group surgical and inhospital medical policies of insurance companies likewise usually cover these cases on the same terms as all other types of cases.

Most companies also sell group policies providing coverage of medical calls in the office and home, usually on a 2- or 3-visit deductible basis. In general these plans cover mental or nervous conditions; however, most are written with the condition that, for the employee, benefits will be paid only if he is disabled.

Within the past 6 years there has been a rapid growth of a type of insurance known as major medical expense insurance, written mainly on a group basis. This insurance supplements the basic hospital, surgical, and medical coverages and usually pays 75 percent of all medical care expense beyond the benefits under the basic coverages and a deductible amount paid by the insured. Within the past 3 years there has been a rapid growth of another type of insurance, called comprehensive medical expense insurance. These policies combine the basic and major medical coverages into a single package. They pay 75 to 85 percent of virtually all medical costs over specified initial deductible amounts and up to high maximum limits.

The practices under these policies in covering mental cases vary. Some policies cover mental illness on the same terms as all other illness. Other plans do this with the proviso that if the employee is not disabled or the dependent hospitalized the rate of reimbursement of expense for psychiatric treatment or consultations will be 50 percent instead of the usual 75 to 85 percent. Still other plans provide reimbursement in mental illness only for patients who are totally disabled or confined in a hospital.

Most of the major medical or comprehensive policies are rather new, and thus experience has been limited. Quite possibly the companies have not yet come fully to grips with the problems of providing care economically and at reasonable costs. In a letter to the author, one large company writes:

"The broad coverage [of mental illness now provided] may be of short duration. In one particular group policy . . . the claims for

Table 4. Blue Shield coverage of mental and nervous conditions, alcoholism, drug addiction, and self-inflicted injuries, March 1957: number of plans with indicated provision

Provision	Nervous and mental conditions	Alcoholism	Drug addiction	Self-inflicted injuries
Covers [1]	33	35	38	54
Excludes	21	25	22	10
Limited coverage	[2] 10	[3] 4	[3] 4	0
Total	64	64	64	64

[1] To the same extent as other types of cases.
[2] 5 cover for a limited period, from 10 to 30 days; 2 cover only in general hospitals; 1 covers for shock therapy only; 1 covers for diagnosis only, and 1 covers except for psychiatric treatment.
[3] 2 cover only in general hospitals; 1 covers for 30 days only; and 1 covers except for psychiatric treatment.

SOURCE: Compiled from data in Blue Shield Manual, as revised to March 1957.

treatment of mental or nervous conditions amounted to well over one-third of the total claims, exclusive of maternity claims. The psychiatric charges at the beginning . . . were in the $20 and $25 bracket and the frequency was averaging between 1 and 2 treatments a week. Gradually the charges increased to $30 a visit and the frequency to 6 times per week with no disability . . . involved.

"Obviously if we are to continue the broad coverage contemplated we must have some pattern which will show an insurable risk—a risk that we can measure and for which we can establish a premium."

Health insurance policies sold to individuals vary perhaps even more widely than group policies, and some companies issue a multitude of different policies with different provisions. Data on number of persons covered under the different provisions are not available. My impression is that the majority of policies exclude mental illness.

Independent Plans

Some of the independent plans are doing interesting experimentation in the coverage of mental illness.

The medical program of the United Mine Workers Welfare and Retirement Fund will

pay for care of patients with mental illness in general hospitals and will provide virtually unlimited care by psychiatrists in the office or outpatient department, to the extent such services are deemed essential. It pays for care in mental hospitals only when the prospect is that the patient will respond to care in a relatively short period, say 1 or 2 months.

The Health Insurance Plan of Greater New York, which provides service through medical groups, excludes alcoholism, drug addiction, and "coverage for psychiatric disorders after diagnosis, for which care is customarily provided by a psychiatrist." Each medical group is required to have a board-certified psychiatrist. The physicians in the group refer patients to him for diagnosis, and in establishing a diagnosis there is usually some form of treatment. However, the groups do not provide shock therapy or analysis. Visits to psychiatrists-neurologists amount to ½ of 1 percent of the total number of services provided by all group physicians to members of the plan.

The Kaiser Foundation Health Plan, which provides services through its own medical groups and hospitals, excludes care for mental illnesses or disorders, attempts at suicide, and alcoholism. However, two of the larger medical centers now have psychiatric clinics. These provide testing and therapy at low fees, usually $5 an hour. The personnel at one clinic includes 2 full-time and 1 part-time psychiatrist, 4 psychologists, and 2 psychiatric social workers. The extra fees charged subscribers do not pay the full expenses of the clinic, which is subsidized by the program as a whole. The program is reported to be very useful in relieving other services of chronic patients whose illnesses are more psychological than somatic.

Group Health Association in Washington, D. C., excludes psychiatric treatment. However, the staff includes two part-time psychologists who provide counseling service to subscribers at a charge of $7 an hour.

The St. Louis Labor Health Institute provides psychiatric service. The staff includes 3 psychiatrists and 1 clinical psychologist, whose hours of service represent about 3 percent of the total of all physician hours.

Most of the large union health centers have part-time psychiatrists on their staffs. Psychiatric visits tend to be about 1 or 2 percent of all visits.

These examples will suffice to indicate practices of independent plans. It is perhaps easier for plans which operate on group-practice principles to experiment with psychiatric coverage than it is for plans providing benefits through free-choice, fee-for-service arrangements.

Notes on Costs and Problems

A few figures may give some idea of the general magnitude of potential costs for coverage of hospitalization for patients with mental illness:

• At present about 2 percent of all patient-days in short-term general hospitals are for patients in the psychiatric units of these hospitals. This fact indicates that on the basis of prevailing practices full coverage of psychiatric cases in general hospitals should not increase a health insurance plan's costs by more than 2 percent.

• If prepayment plans undertook responsibility for the first 60 days of all admissions to all mental hospitals, including State institutions, and provided an average of 45 days per admission, they would assume liability for days of care amounting to an additional 10 percent of all days for general care. Since the cost per day in mental hospitals is, of course, lower than for general hospitals, this would represent less than a 10 percent increase in costs.

• One Blue Cross plan which covers mental cases for 120 days in general hospitals and for 30 days in other hospitals reports that its payments for mental, psychoneurotic, and personality disorder cases amount to 3.2 percent of its total inpatient payments. An insurance company estimates that under its basic hospitalization plans 3 to 5 percent of its hospital expense is for psychoneurotic disorders.

Among the problems in providing coverage for mental illness are the costs, in a setting where all types of plans are finding their costs expanding; the indeterminateness of these costs particularly when care over a long period in a hospital or physician's office is required; the question of how mental hospitals in this country should be financed and of demarcation of

the respective roles of patients, private insurance, and government in financing mental hospital care. All real coverage of psychiatric care in the office must await the development of prepayment for physicians' services generally in the office and home, a field in which experimentation and pioneering are the order of the day.

A quotation from a letter I received from the director of one independent prepayment plan may well sum up the present position of prepayment plans and insurance carriers on coverage for psychiatric care:

"It seems to me that the most important fact is that no one has any idea as to what the utilization of complete psychiatric services would be if they were available on an insured basis. It is our hope, therefore, to extend coverage in this field bit by bit so as to learn as we go along, while avoiding too great a risk."

National Health Survey Advisory Committee

To enhance the usefulness of the U. S. National Health Survey of the Public Health Service, an advisory committee has been set up to include representatives of the health professions, insurance firms, labor, and other users of health statistics.

The new committee will review the plans and progress of the survey and help formulate principles and methods of cooperation with interested public and private organizations.

Leroy E. Burney, Surgeon General of the Public Health Service, is chairman of the committee, and George St.J. Perrott, chief of the Service's Division of Public Health Methods, serves as executive secretary.

The committee held its first meeting November 22, 1957.

Members of the committee are: Dr. Karl Bambach, vice president, American Drug Manufacturers Association, Washington, D. C.; Dr. Leona Baumgartner, commissioner of health, New York City; Pearl Bierman, medical care consultant, American Public Welfare Association, Chicago, Ill.; Dr. Paul E. Boyle, dean, School of Dentistry, Western Reserve University, Cleveland, Ohio; James Brindle, director, Social Security Department, United Auto Workers, Detroit; Arthur M. Browning, vice president, New York Life Insurance Co., New York City; Dr. W. D. Bryant, executive director, Community Studies, Inc., Kansas City, Mo.

Other members are: Dr. Bernard Bucove, State director of health, Olympia, Wash.; Dr. Robin C. Buerki, executive director, Henry Ford Hospital, Detroit; George Bugbee, president, Health Information Foundation, New York City; Dr. Antonio Ciocco, head, Department of Biostatistics, Graduate School of Public Health, University of Pittsburgh; James F. Coleman, president, United Medical Service, Inc., New York City; Dr. J. S. Denslow, professor and director of research affairs, Kirksville College of Osteopathy and Surgery, Kirksville, Mo.; Dr. Robert P. Fischelis, secretary, American Pharmaceutical Association, Washington, D. C.

Also on the committee are: Dr. Norvin C. Kiefer, chief medical director, The Equitable Life Assurance Society of the United States, New York City; Dr. Allister M. Macmillan, Department of Sociology and Anthropology, Cornell University, Ithaca, N. Y.; Dr. Ross A. McFarland, Department of Industrial Hygiene, School of Public Health, Harvard University, Boston; Dr. H. B. Mulholland, Department of Internal Medicine, School of Medicine, University of Virginia, Charlottesville; Dr. Peter M. Murray, board of trustees, State University of New York, Albany.

Completing the list of members are: Marian G. Randall, R.N., executive director, Visiting Nurse Service of New York; Dr. Vergil D. Reed, vice president, J. Walter Thompson Co., New York City; Dr. James H. Sterner, medical director, Eastman Kodak Company, Rochester, N. Y.; James E. Stuart, executive director, Hospital Care Corporation, Cincinnati, Ohio; and Dr. Ray E. Trussell, executive officer, School of Public Health and Administrative Medicine, Columbia University, New York City.

publications

Cost Analysis for Collegiate Programs In Nursing

Part I. Analysis of expenditures
Part II. Current income and other resources

National League for Nursing and PHS Publication. By Leslie W. Knott, Ellwynne M. Vreeland, and Marjorie Gooch. Part I, 1956, 166 pages; $3.50. Part II, 1957, 46 pages; $2.00.

Although these manuals are focused on analyzing costs of nursing education, the techniques and methods described should prove useful for other types of education programs.

Part I contains a general discussion of underlying principles, defines terms, and describes the methods used. Part II, in addition to discussing the usual sources of education income, includes suggested methods for evaluating student service.

Schedule forms for organizing and anaylzing cost information are presented with illustrative data based on a fictitious university carried through the analysis step by step.

Copies can be obtained from the National League for Nursing, 2 Park Avenue, New York 16, New York.

Reported Tuberculosis Data, Calendar Year 1955

PHS Publication No. 560. 1957. By Stanley Glaser and Paul L. Roney. 29 pages. 25 cents.

This fourth annual summary presents data supplied to the Public Health Service on the Annual Tuberculosis Report by all the States, the District of Columbia, Alaska, Hawaii, and Puerto Rico.

The data cover newly reported tuberculosis cases for the United States and each State by source of morbidity report, activity status, form and extent of the disease, race, sex, and age, as well as X-ray case-finding activities, mortality, and public health nursing visits.

An analysis of each table summarizes data for the years 1952 through 1955 and points out pertinent characteristics inherent in the data.

Biological Products

PHS Publication No. 50. Revised April 15, 1957. 52 pages.

Superseding Public Health Service Publication No. 50, revised April 15, 1955, this edition lists the establishments holding licenses for the preparation and sale of viruses, serums, toxins and analogous products, and the trivalent organic arsenic compounds.

Comparative Mortality Among Metropolitan Areas of the United States, 1949–51

102 causes of death

PHS Publication No. 562. 1957. By Nicholas E. Manos. 143 pages. $3.25.

This graphic and tabular presentation of 1949–51 mortality, from 102 causes, in the United States includes ratios of observed to expected mortality for 163 metropolitan areas; mortality rates and ratios by degree of urbanization; and background material necessary to the interpretation of these data. It was prepared under the direction of the Air Pollution Medical Program, Public Health Service.

Mortality ratios are emphasized as a tool for comparative analysis, and mortality data are presented in greater geographic detail than has heretofore been available.

The 102 causes of death are grouped into 10 categories, including respiratory system diseases, circulatory system diseases, malignant neoplasms, and a group of miscellaneous diseases and conditions. Mortality comparisons from city to city, by cause, as well as comparisons between the central city and outlying areas of the 163 metropolitan areas, are shown.

While no analysis accompanies the statistics, the graphic form of presentation points up variations which suggest possible areas of research on the effects of environmental factors on mortality.

Meeting Community Sewage Treatment Needs Under the Construction Grants Program

PHS Publication No. 558. 1957. Folder.

The Federal grant program for construction of sewage treatment works, authorized under the Federal Water Pollution Control Act, Public Law 660, 84th Cong., is briefly described. Eligibility requirements and application procedures are outlined, and State water pollution control agencies cooperating with the Public Health Service in administering the program are listed.

Handbook of Selected Biological References on Water Pollution Control, Sewage Treatment, Water Treatment

Public Health Bibliography Series No. 8. PHS Publication No. 214. Revised 1957. By William Marcus Ingram. 95 pages; illustrated. 45 cents.

This revised handbook lists by subject numerous biological publications relating to various aspects of water pollution, waste treatment, and water supply that have appeared in recent technical literature. The references were selected on the basis

of their availability and potential usefulness to those not trained primarily in biology. The intent of the handbook is to provide information fundamental to a good understanding of biological problems that could arise in the course of water pollution control and related work.

A list of references on organism identification is included. Basic readings on ecology and water treatment are suggested in the introduction.

Facts About the Federal Water Pollution Control Act of 1956

PHS Publication No. 555. 1957. 16 pages. 15 cents.

Intended for community leaders, State and municipal officials, and others interested in control of water pollution, this booklet outlines briefly the provisions of the Federal Water Pollution Control Act of 1956 (Public Law 660, 84th Cong.) and the Public Health Service program authorized by the new law. Activities under this program include comprehensive program development, interstate cooperation, research and technical assistance, collection of basic data, State and interstate program grants, construction grants, and enforcement measures against interstate pollution.

Background information on earlier Federal legislation for pollution control is given, and the role which control of pollution plays in augmenting and conserving water resources to meet increasing demands is described.

How To Study Supervisor Activities in a Hospital Nursing Service

PHS Publication No. 496. 1957. By Elinor D. Stanford and others. 47 pages. 40 cents.

Third in a series developed by the Division of Nursing Resources, Public Health Service, for use by hospitals and others desiring to study nursing personnel activities, this manual provides the supervisor with a method for examining her actual activities in relation to the functions which she believes appropriate to her job. The steps in the study and the method of observation employed are described in detail.

Instructions for training observers and for tabulating material are included.

Directory of Full-Time Local Health Units, 1957

PHS Publication No. 118. Revised 1957. 70 pages. 30 cents.

This listing of full-time health units serving local areas, together with the name of the health officer of each unit or other designated administrative head, was revised July 1957. The local units are listed by State, giving in each instance the health area jurisdiction, post office address, and the health officer's name and official title.

Facts About Indian Health

PHS. Publication No. 479. Revised June 1957. 8 pages.

With up-to-date statistics and facts, this revised edition describes briefly the Indian health problem and the program of the Division of Indian Health, Public Health Service.

Socioeconomic Characteristics of Persons Who Married Between January 1947 and June 1954: United States

Vital Statistics—Special Reports. Selected Studies. Vol. 45, No. 12, Sept. 9, 1957. By Hugh Carter, Sarah Lewitt, and William F. Pratt. Pages 271–353; tables and charts. 45 cents.

Based on a sample survey of persons who married between January 1947 and mid-June 1954, data are given on residence at time of marriage as related to place of marriage, number of times previously widowed or previously divorced, number of times married, age at marriage, years of school completed, labor-force status of wife, and major industry group of husband.

There are cross tabulations of characteristics of the husband as related to those of the wife, as well as separate tabulations for husbands and wives. An analytical text, text tables, and charts precede 30 detailed tables of basic data.

The data were obtained through a special supplementary survey carried out by the Bureau of the Census in its current population survey. Tables of sampling errors are included.

Facts on Mental Health and Mental Illness

PHS Publication No. 543. 1957. 11 pages. 10 cents.

Known facts about mental illness are summarized and the need to know more is pointed out in this booklet. It shows the scope of the problem and cites new knowledge gleaned through recent research as well as progress made in the care, treatment, and rehabilitation of the mentally ill, and in the training of specialists in the mental health field. What is needed to solve this major health problem is outlined.

This section carries announcements of new publications prepared by the Public Health Service and of selected publications prepared by other Federal agencies.

Unless otherwise indicated, publications for which prices are quoted are for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order and should fully identify the publication. Public Health Service publications which do not carry price quotations, as well as single sample copies of those for which prices are shown, can be obtained without charge from the Public Inquiries Branch, Office of Information, Public Health Service, Washington 25, D. C.

The Public Health Service does not supply publications other than its own.

U. S. GOVERNMENT PRINTING OFFICE: 1958